Maryland Health Care Commission

Thursday, September 20, 2018

1:00 p.m.

MARYLAND HEALTH CARE COMMISSION

AGENDA

1. **APPROVAL OF MINUTES**
2. UPDATE OF ACTIVITIES
3. ACTION: Certificate of Need – Children's Hospital (a subsidiary of Children's National Medical Center, Inc.) - Docket No. 18-16-2413
4. ACTION: Exemption from Certificate of Need Review for the Conversion of UM Capital Region Health Laurel Regional Hospital to a Freestanding Medical Facility - Docket No. 18-16-EX002
5. ACTION: Change in Approved Certificate of Need – Adventist HealthCare, Inc. *d/b/a* Washington Adventist Hospital - Docket No. 13-15-2349
6. ACTION: COMAR 10.24.17 – State Health Plan for Facilities and Services: Cardiac Surgery and Percutaneous Coronary Intervention Services – Proposed Permanent Regulations
7. PRESENTATION: 2017 Findings: Health Care Data Breaches in Maryland
8. PRESENTATION: Telehealth Grant Findings: Johns Hopkins Pediatrics at Home Health East Baltimore Asthma Assessments, and University of Maryland Shore Regional Health Palliative Care/Emergency Department Psychiatric Services in rural communities of the Ea
9. PRESENTATION: Maryland Health Workforce Study
10. OVERVIEW OF UPCOMING INITIATIVES
11. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

APPROVAL OF MINUTES

(Agenda Item #1)

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

(Agenda Item #2)

MARYLAND HEALTH CARE COMMISSION

Certificate of Need Modernization

An Update

Maryland Health Care Commission
September 20, 2018

Modernizing CON Regulation – Charge to Commission

1. Examine major policy issues
2. Review approaches other states use to determine appropriate capacity
3. Recommend revisions to CON statute
4. Recommend revisions to State Health Plan (SHP) regulations
   - Incentivize reductions in unnecessary utilization
   - Eliminate, consolidate or revise individual chapters
   - Develop criteria that determine service need in the context of Maryland's All-Payer Model
   - Improve clarity and appropriateness - reduce ambiguity
5. Consider flexibility needed to streamline CON project review process
6. Identify areas of regulatory duplication – MHCC, HSCRC & MDH

Modernizing CON Regulation – MHCC Response

- **Phase One**
  - **Identification of problems that need to be addressed in modernizing CON regulation, with assistance of a stakeholder Task Force**
  - ***Interim Report on Modernization of the Maryland Certificate of Need Program*, June 1, 2018**
- **Phase Two**
  - **Develop consensus, to the extent possible, with assistance of an expanded stakeholder Task Force, on the legal, regulatory, and process changes that are practical and best address the identified problems**
  - **Develop Final Report for General Assembly Committees (December 2018)**

CON Modernization Task Force – Phase Two

- Three Phase Two meetings of Task Force to date, covering:
  - Guiding principles for reform
  - CON regulation of five facility and service categories:
    - Comprehensive care facilities (nursing homes)
    - Home health agency services
    - General hospice services
    - Alcoholism and drug abuse treatment intermediate care facilities
    - Residential treatment centers

- At least three additional meetings planned. Discussion will cover:
  - Hospital and ambulatory surgical facility services
  - Project review and other regulatory process reform
  - The final report by MHCC to the General Assembly Committees

Guiding Principles for CON Regulation Reform

1. **Promote the availability of general hospital and long term care services in all regions of Maryland. Assure appropriate availability of specialized services that require a large regional service area to assure viability and quality.**

2. **Complement the goals and objectives of the Maryland Total Cost of Care Model.**

3. **Provide opportunities to enter the Maryland market for innovators committed to the delivery of affordable, safe, and high-quality health care.**

4. **Minimize the regulatory requirements for existing providers to expand existing capacity or offer new services when those providers are committed to the delivery of affordable, safe, and high-quality health care.**

5. **Reduce the burden of complying with CON regulatory requirements to those necessary for assuring that delivery of health care will be affordable, safe, and of high-quality.**

6. **Maintain meaningful review criteria and standards that are consistent with the law and understandable to applicants, interested parties, and**

Key Reform Concepts Discussed

COMPREHENSIVE CARE FACILITIES (CCFs or NURSING HOMES)

- Eliminate use of capital expenditure thresholds as a basis for requiring a CON
- Provide opportunities for new CCFs or expanded CCFs to be developed in jurisdictions with no identified need for additional beds if existing CCFs in the jurisdiction are poor performers (e.g., using CMS Nursing Home Compare ratings)
- Develop an abbreviated review process for certain types of CCF projects (e.g., expanding capacity, replacing facilities on the same site or an adjacent site)
- Expand the ability for CCFs to add beds without a CON (the "waiver" process) beyond current limitations (i.e., more than lesser of 10 beds or 10% of existing beds every two years)
- Allow docketing for new CCFs or expanded CCFs in jurisdictions with no identified bed need if the project is well aligned with the objectives of the Total Cost of Care payment model
- Allow CCFs to establish home health agencies or hospice services without need for CON approval

Key Reform Concepts Discussed

HOME HEALTH AGENCIES (HHAs)

- **Eliminate use of capital expenditure thresholds as a basis for requiring a CON**
- **Limit standards used in CON regulation to provider's history as a quality provider**
- **Allow CCFs to establish home health agencies without need for CON approval**
- **Develop an abbreviated review process for expanding service areas for HHAs if good performers**
- **Eliminate all CON regulation of HHAs – This could be coupled with development of alternatives to CON regulation (e.g., licensing reform) to serve as a "gatekeeper," keeping "bad actors" from developing HHAs in Maryland**
- **Eliminate CON regulation of existing HHAs allowing HHAs to expand into new jurisdictions without need for CON**
- **Allow waiver of CON requirements for projects endorsed by HSCRC that advance the objectives of the Total Cost of Care payment model**

Key Reform Concepts Discussed

GENERAL HOSPICES

- **Eliminate use of capital expenditure thresholds as a basis for requiring a CON**
- **Eliminate need for CON to change hospice bed capacity**
- **Limits issues in CON regulation of hospices to impact**
- **Reform State Health Plan (SHP) to provide an opportunity for new or expanded hospices in jurisdictions with only one authorized hospice (currently 12 to 14 jurisdictions)**
- **Develop an abbreviated review process for expanding service areas for hospices if good performers – could be limited to contiguous jurisdictions**
- **Eliminate all CON regulation of hospice – This could be coupled with development of alternatives to CON regulation (e.g., licensing reform) to serve as a "gatekeeper," keeping "bad actors" from developing hospices in Maryland – limitations on rate of growth in supply of hospices could also be included**
- **Allow waiver of CON requirements for projects endorsed by HSCRC that advance the objectives of the Total Cost of Care payment model**

Key Reform Concepts Discussed

ALCOHOLISM/DRUG ABUSE TREATMENT INTERMEDIATE CARE FACILITIES (ICFs)

- Eliminate use of capital expenditure thresholds as a basis for requiring a CON
- Eliminate need for CON to relocate an ICF or change ICF bed capacity
- Limit issues in CON regulation of hospices to impact and financial impact
- Eliminate all CON regulation of ICFs that are primarily funded through public payment sources
- Eliminate all CON regulation of ICFs – This could be coupled with development of alternatives to CON regulation (e.g., licensing reform) to serve as a "gatekeeper," keeping "bad actors" from developing ICFs in Maryland

Key Reform Concepts Discussed

RESIDENTIAL TREATMENT CENTERS (RTCs)

- **Eliminate use of capital expenditure thresholds as a basis for requiring a CON**
- **Eliminate need for CON to relocate an RTC or change RTC bed capacity**
- **Limit issues in CON regulation of RTCS to whether or not the project is supported by juvenile justice agencies and impact**
- **Eliminate all CON regulation of RTCs – This could be coupled with development of alternatives to CON regulation (e.g., licensing reform) to serve as a "gatekeeper," keeping "bad actors" from developing RTCs in Maryland**

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Certificate of Need – Children's Hospital (a subsidiary of Children's National Medical Center, Inc.) – Docket No. 18-16-2413

(Agenda Item #3)

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Exemption from Certificate of Need Review for the Conversion of UM Capital Region Health Laurel Regional Hospital to a Freestanding Medical Facility – Docket No. 18-16-EX002

(Agenda Item #4)

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

ACTION:

Change in Approved Certificate of Need – Adventist HealthCare, Inc. *d/b/a* Washington Adventist Hospital - Docket No. 13-15-2349

(Agenda Item #5)

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

ACTION:

COMAR 10.24.17 – State Health Plan for Facilities and Services: Cardiac Surgery and Percutaneous Coronary Intervention Services – Proposed Permanent Regulations

(Agenda Item #6)

MARYLAND HEALTH CARE COMMISSION

Re-Proposed Regulations: State Health Plan Chapter for Cardiac Surgery and Percutaneous Coronary Intervention Services (COMAR 10.24.17)

Maryland Health Care Commission
September 20, 2018

Factors Affecting the Additional Changes

- Formal comments received
- Feedback from the American College of Cardiology (ACC) and Society of Thoracic Surgeons (STS)
- Changes to the payment model for Maryland hospitals (Updated agreement between CMS & HSCRC)
- Addition of a new primary percutaneous coronary intervention (PCI) program
- Updated information available on volume trends for PCI and cardiac surgery services

.03 Issues and Policies

- Updated the description of the payment model for Maryland hospitals
- Updated description of access to primary PCI services
- Updated information on the trends in volume for PCI and cardiac surgery services

.04 Commission Program Policies

- Staff revised .04A(b) after consultation with staff for the Health Services Cost Review Commission. These changes are shown below with strikethroughs for deleted language and underlining of new language.

(b) A hospital shall have a current population ~~based~~ health budget ~~agreement, a total patient~~ revenue agreement with the Health Services Cost Review Commission before a hospital's CON application to establish a cardiac surgery program will be docketed.

.06 Certificate of Conformance Criteria

- Staff revised .06A(6)(a), .06A(7)(a), .06B(5)(a), and .06B(5)(b) have been revised to refer to “Expert Guidelines.”

- Specific standards that were directly referenced include:

  - ACCF/AHA/SCAI 2013 Update of the Clinical Competence Statement on Coronary Artery Interventional Procedures
  - ACCF/AHA Management of Patients with Acute Myocardial Infarction
  - ACCF/AHA/SCAI Guidelines for Percutaneous Coronary Intervention

.07 Certificate of Ongoing Performance

- Staff revised the standards .07B(4)(a), .07C(4)(f), and .07D(5)(e). Each contains similar language and has been revised similarly. One example, changes to .07B(4)(a), is shown below.

4) Quality.

(a) The chief executive officer of the hospital shall certify ~~annually to the~~ upon request by Commission staff that the hospital fully complies with each requirement for conducting and completing quality assurance activities specified in this chapter, including those regarding internal peer review of cases and external review of cases.

.07 Certificate of Ongoing Performance

- Staff revised standard .07B(5)(a)(i) in order to address a situation where a hospital fails to receive a star rating for its composite coronary artery bypass graft (CABG) cases. The revised standard is shown below.

(i) The hospital shall maintain an STS-ACSD composite score for CABG of two stars or higher. If the composite score for CABG from the STS-ACSD is one star, or if a hospital fails to receive a star rating, for four consecutive rating cycles, the hospital's cardiac surgery program shall be evaluated for closure based on a review of the hospital's compliance with State regulations and recently completed or active plans of correction. Upon notice from the Executive Director of the Commission, the hospital shall voluntarily relinquish its authority and close its cardiac surgery services in a timely manner.

.07 Certificate of Ongoing Performance

- Staff revised standard .07B(5)(b) to refer to the national average as the benchmark for all-cause 30-day risk-adjusted mortality rates, rather than the State average.

- This change is consistent with feedback from the Commission at the July Commission meeting and a formal comment from the Maryland Cardiac Surgery Quality Initiative (MCSQI) on this standard.

- Staff concludes this change is also necessary because the contractor for STS is not be readily able to provide a statewide average without developing a new statistical model specifically for this purpose.

.07 Certificate of Ongoing Performance

Comment:

- MCSQI suggested MHCC should rely on only composite STS measures instead of risk-adjusted CABG mortality rates.

Recommendation:

- Staff recommends no change in response to this comment. The composite star ratings are largely determined by mortality rates, and these rates are more readily understandable than composite measures.

.07 Certificate of Ongoing Performance

Comment:

- MCSQI also suggested that a minimum of 12 months of data should be included for any analysis of risk adjusted mortality rates for CABG cases.

Recommendation:

- Staff recommends no change in response to this comment because the agreement between MHCC and STS ensures that a 12-month period will be used for this analysis.

.07 Certificate of Ongoing Performance

- Standard .07B(6)(c) has been added to address programs that maintain a volume below 100 cases for more than two consecutive years. This standard is shown below.

(c) A cardiac surgery program that fails to reach an annual volume of 100 cases for three or more consecutive years will be subject to a focused review for cases performed in the 12-month period following the prior focused review, unless the Executive Director determines that a 24-month period is appropriate, based upon considerations that include the results of the prior focused review, patient outcomes for morbidity and mortality, and the cardiac surgery program's recent STS star ratings.

.07 Certificate of Ongoing Performance

- Staff revised standard .07C(5)(c) to refer to “non-STEMI” PCI cases rather than “elective” PCI cases. This change is consistent with the performance metric information provided by the ACC to hospitals.

- This standard has also been revised to refer to the “median” in-hospital risk adjusted mortality rate instead of the “average” rate.

.07 Certificate of Ongoing Performance

- Staff revised standard .07D(6)(c) to refer to “STEMI” PCI cases rather than “primary” PCI cases. This change is consistent with the performance metric information already provided by the ACC to hospitals.

- This standard has also been revised to refer to the “median” in-hospital risk adjusted mortality rate instead of the “average” rate.

.08 External Peer Review

- The standards .08C(1)(c),(d),(f), and (h) have been revised to refer to “Expert Guidelines” rather than specific guidelines currently referenced.

- Similar changes are included elsewhere in the regulations, as previously noted.

- As guidelines become updated, it will be easier to accurately reference the new guidelines, with the revised language for these standards.

.11 Definitions

Staff has added two definitions, as shown below.

(12) "Expert Guidelines" means the applicable guidelines adopted by the American College of Cardiology Foundation (ACC or ACCF), American Heart Association (AHA), or Society for Cardiovascular Angiography and Interventions (SCAI), or a combination of at least two of these organization with or without other collaborating organizations that are referenced by a dated posting on the Commission's website and published in the Maryland Register.

(20) "Non-STEMI" means a heart attack in which a patient's cardiac biomarkers exceed the upper limit of normal according to an individual hospital's laboratory parameter, and the patient has a clinical presentation that is consistent or suggestive of ischemia and the absence of ECG changes diagnostic of a STEMI.

Request for Approval

Staff requests that the Commission adopt draft COMAR 10.24.17, the State Health Plan for Facilities and Services-Cardiac Surgery and PCI Services, as re-proposed permanent regulations and repeal current COMAR 10.24.17, contingent on the replacement regulations becoming effective.

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MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

2017 Findings: Health Care Data Breaches in Maryland

(Agenda Item #7)

Health Care Data Breaches

2017 Findings

September 20, 2018

The MARYLAND HEALTH CARE COMMISSION

2017 Key Takeaways

- Reported breaches up 10% from 2016*
  - Maryland ranks 18th among states with the largest number of reported breaches improving (descending) two spots since 2016
- Steep decline in total records compromised by as much as 69% nationally and 92% locally***
- Hacking/IT breaches growing at a faster rate than other breach types in the nation and Maryland, and accounts for the majority of all records compromised
- High profile incidents like the Equifax breach and WannaCry virus highlight the importance of cybersecurity best practices

*Notes: *Refer to slides 14 and 15 for information on the top 10 breaches in the nation and all breaches in Maryland; **Refer to slide 16 for more information on breaches by covered entity type; ***Refer to slide 17 for information on breach occurrences and records compromised from 2014-2017*

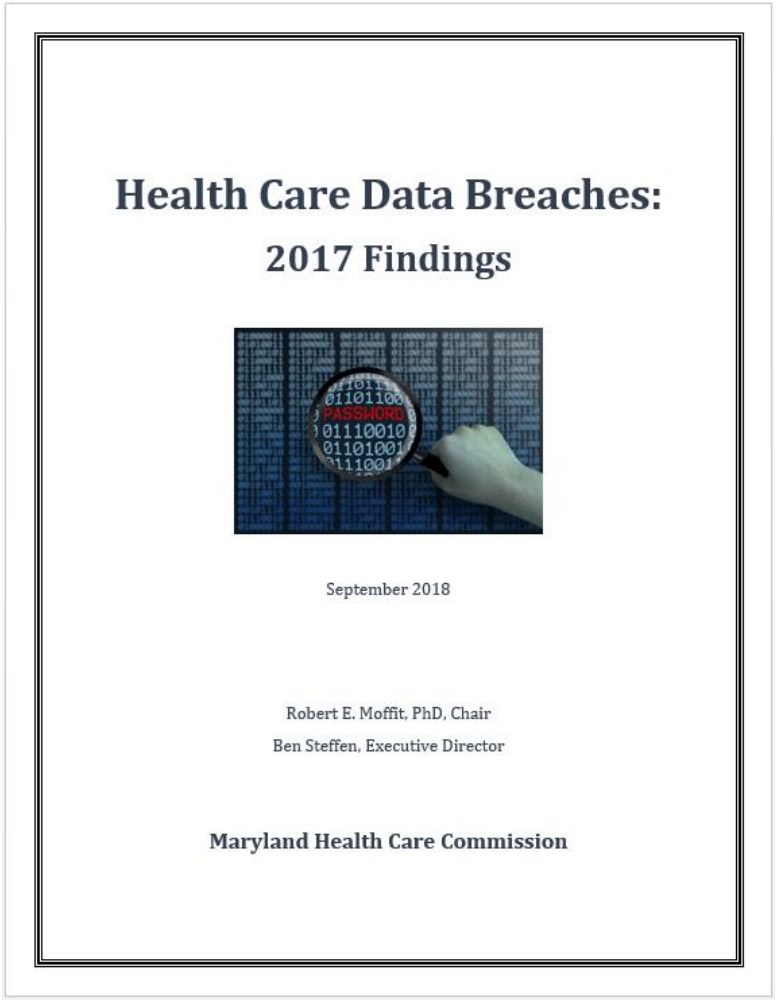
A Snapshot of Maryland

- Reported breaches in Maryland remains fairly consistent
- Total of eight breaches in 2017, an increase of two (33%) from the prior year*
  - Seven (88%) health care providers; one (12%) business associate
- Hacking/IT accounts for 50% of all reported breaches and 95% of all records compromised
- Maryland ranks 20th among states for the largest number of records compromised, improving (descending) 14 spots since 2016

*Note: *Maryland reported six breaches in 2014, eight breaches in 2015, and six breaches in 2016 – refer to slide 17 for more information*

About the Assessment

- Analysis of breaches in Maryland and the nation affecting >500 individuals
  - **2016**: Maryland: N=6; Nation: N=326
  - **2017**: Maryland: N=8; Nation: N=359
  - **2018**: Maryland n=7; Nation n=221
    (preliminary – as of August 2018)
- Data obtained from the Office for Civil Rights (OCR) Online Portal



Note: 2017 and 2018 data consist of breaches investigated and closed and currently under investigation

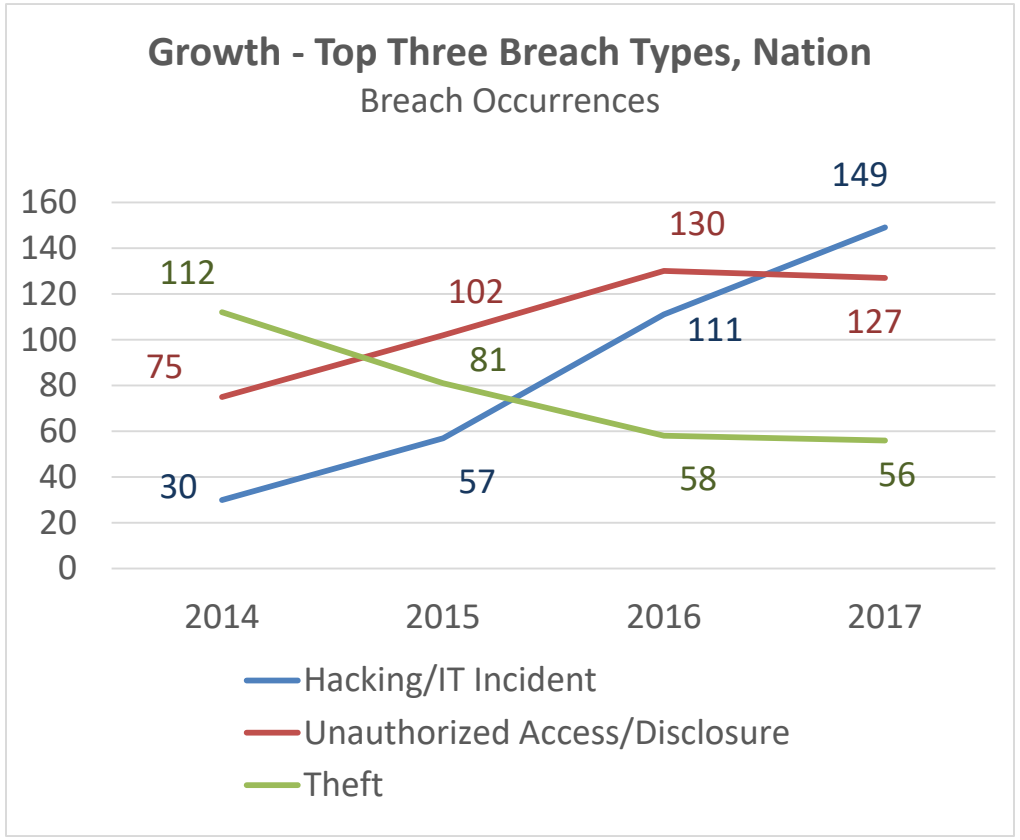
Breach Types

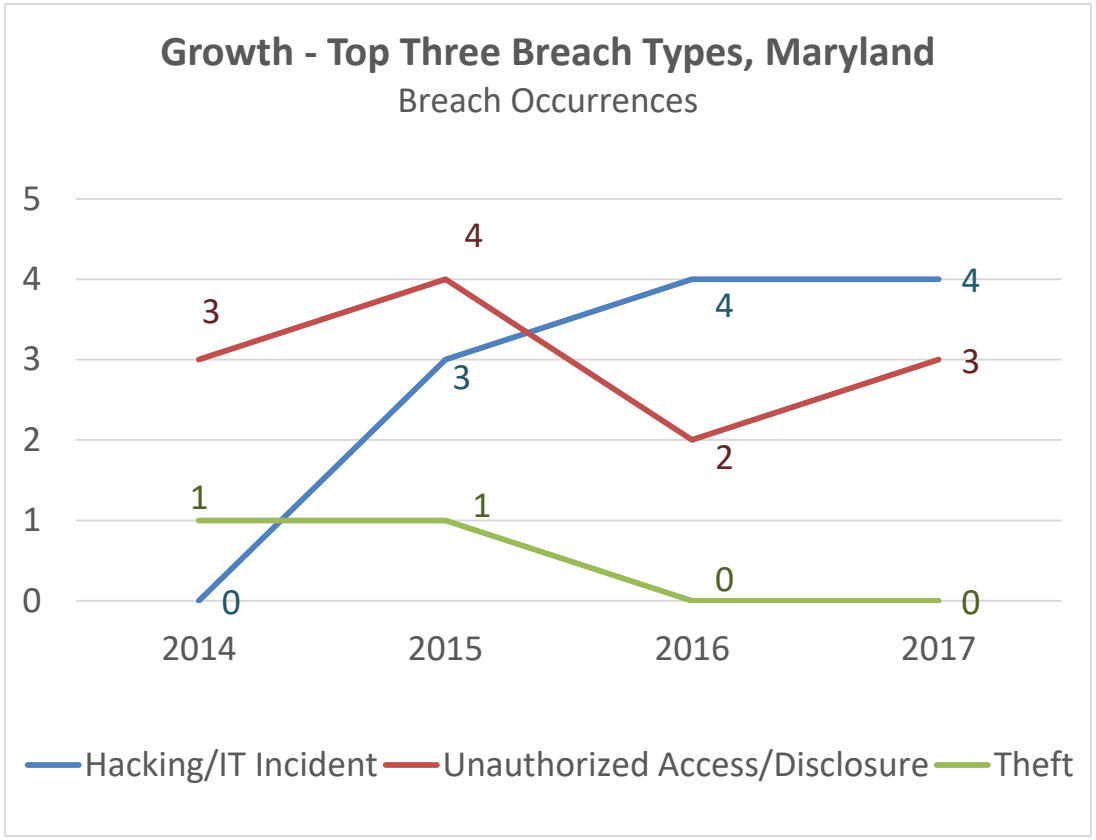
- Exponential growth in hacking/IT since 2014
  - 71% compound annual growth rate in the nation
- Hacking/IT accounted for the majority of breaches surpassing unauthorized access/disclosure, the first time for the nation and the second year in a row for Maryland

Breach Type	Hacking/IT		Unauthorized Disclosure/Access	
Year	**2016**	**2017**	**2016**	**2017**
Nation (%)	34	42	40	35
Maryland (%)	67	50	33	38

- Most other breach types (i.e., theft, loss, improper disposal) are becoming less frequent

Breach Types *(continued…)*



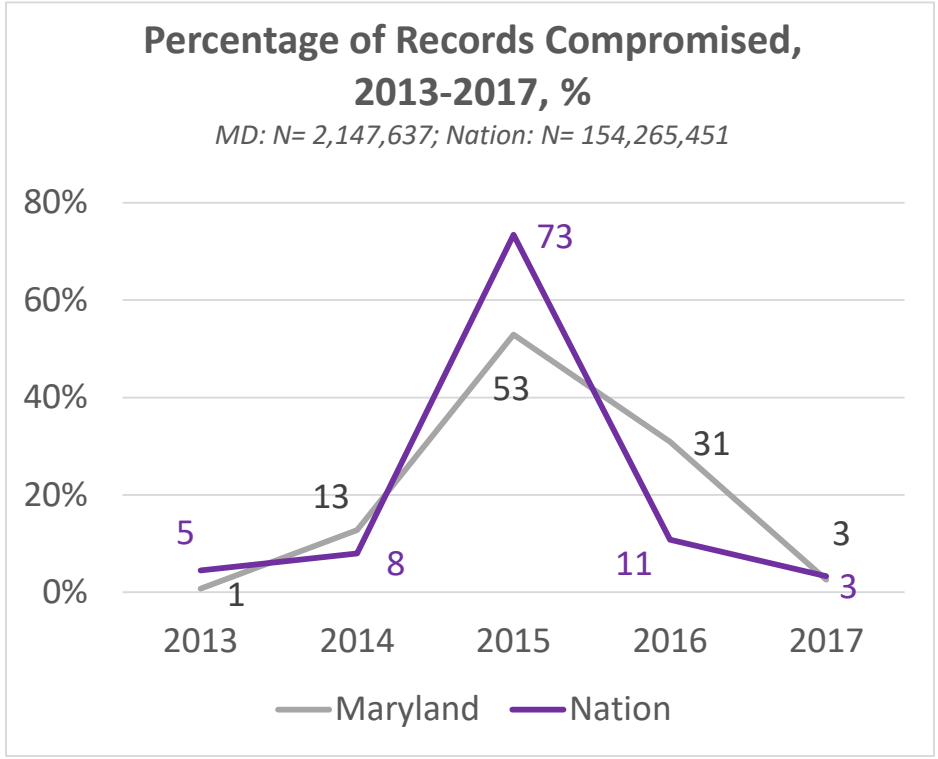


Note: Other breach types occurred (i.e., loss, improper disposal) for a small portion of breaches and are not represented in these figures.

Records Compromised

- Significant decrease in total records compromised since 2015
  - All breaches reported in 2017 affected fewer than 1 million records
- Largest breach reported by Kentucky impacted 697,800 records and is attributed to insider-wrongdoing
- Maryland ranks 4th among comparable states (IN, MO, CO, NJ, AZ, and CT)* improving (descending) one spot since 2016

*See slide 18 for more information on comparable states



Notes: The graph depicts the distribution of records compromised by year.
Breaches in 2015 compromised the greatest number of records to date in Maryland and the nation, including Anthem BlueCross (~78.8M records), Premera BlueCross (~11M records), Excellus BlueCross BlueShield (~10M records), and CareFirst BlueCross BlueShield (~1.1M records).

Breach Location

- e-Mail increased the greatest by 10% nationally and 33% locally*
  - Cited most frequently in Maryland (50%); second leading breach location in the nation (25%)
- Network server cited most frequently for the nation (31%) and compromised the majority of records, consistent with 2016
- Local breaches citing electronic medical record/network server account for the most records compromised (63%)
  - e-Mail accounts for the remaining third of records compromised

*Note: *Refer to slide 19 for breakdown of occurrences and records compromised by breach location*

A Preliminary View of 2018

- Hacking/IT continues to account for an ample portion of reported breaches (Nation: 39%; MD: 71%) and records compromised (Nation: 62%; MD: 95%)
- Total records compromised nationally remains about the same, as compared to Maryland which has increased tenfold*
- Maryland did not improve ranking 3rd for total number of records compromised (ascending 17 spots since 2017) and 8th for number of reported breaches (ascending 10 spots since 2017)
  - Includes third largest reported breach impacting >500K records

Notes:
Preliminary data includes breaches reported as of August 2018
**Refer to slide 20 for more information on 2018 breaches*

Phase 2 OCR Audit Program

- Goal: Uncover leading breach causes and develop guidance to improve industry-wide risk management and best practices for breach prevention
- Includes investigations of breaches affecting <500 individuals
- Preliminary results suggest broad compliance challenges
  - 94% of audited organizations failed to demonstrate appropriate risk management procedures

Outlook

- Cybercrime growing in complexity (new forms of malware); insider threats increasing risk of a breach
- Continued evidence of organizations increasing spend and implementing more robust security measures
  - Seeking ways to deploy secondary authentication methods (not password-only; using multi-factor, such as security tokens)
- Growing efforts to safeguard consumer data through new legislation
  - Amendments to the Maryland Personal Information Protection Act effective October 1, 2018

The MARYLAND
HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

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Telehealth Grant Findings: Johns Hopkins Pediatrics at Home Health East Baltimore Asthma Assessments, and University of Maryland Shore Regional Health Palliative Care/Emergency Department Psychiatric Services in rural communities of the Eastern Shore

(Agenda Item #8)

Telehealth Grant Projects:

Population Health in Rural Communities Telehealth Technology Grant
&
Mobile Health Grant

September 20, 2018

The MARYLAND
HEALTH CARE COMMISSION

Background

- Since 2014, MHCC has awarded over $850K in grants with over $1.57M in matching funds to 14 provider organizations to demonstrate the impact of using telehealth
- Grants have helped to inform: 1) better practices; 2) industry implementation and expansion efforts; 3) policies that can support advancement of telehealth; and 4) the design and implementation activities of telehealth projects across the State of Maryland
- Grants have served as a catalyst for organizations to expand telehealth programs

The Virtual Visit

- An alternative to the consumer at that time – does not replace office visits
- Targets the process of care delivery – access and availability
- Provides coordinated care throughout the care continuum when coupled with health information exchange

Projects Overview

- Projects were for 18-month totaling $175,149 in grant funds with $350,303 matched by grantees

- University of Maryland Shore Regional Health (UM SRH): Jan. 2017 – July 2018

  - Project 1: Implemented telehealth to provide palliative care services to patients within University of Maryland Shore Medical Center at Chestertown (UMSMC-C) and Shore Nursing and Rehabilitation Center at Chestertown

  - Project 2: Via telehealth, provided ED psychiatric services at UMSMC-C and Shore Regional Emergency Center at Queen Anne's and inpatient psychiatric consultations at UMSMC-C

Projects Overview *(Continued)*

- Pediatrics at Home (PAH): Dec. 2016 – June 2018

  - Used mobile health (mhealth) to manage pediatric asthma in patients of Johns Hopkins Community Physicians practices in Baltimore City

  - A mobile application facilitated regular health assessments, use of the patients Asthma Action Plan, real time-time clinical and educational feedback, and secure communication between the patient and a PAH nurse

Key Observations

- UM SRH
  - Technology increased access to palliative care by three fold without increasing staffing
  - Technology enabled psychiatric patients to receive care at Centerville and Chestertown Hospitals that would previously require a transfer
- PAH
  - Patients were able to monitor symptoms and readily access educational information and clinical services
  - Strong provider and patient relationships are a key component to effective use of technology

Telehealth Grants

UM SRH and PAH

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

MHCC Telehealth Project 17-004

Palliative Care & Psychiatry

Presented by Lakshmi Vaidyanathan, MD, MBA
Medical Director
Shore Regional Palliative Care Program

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

I. About the Project
II. Data Collection
III. Outcomes
IV. Challenges
V. Solutions
VI. Project Observations
VII. Sustainability

About the Project

Award: $ 75,149

Emergency Psychiatric Care: Kent and Queen Anne's counties

Specialized Palliative Care: Kent County

Goal: Study the impact of telehealth specialty care on population health and access to care in rural communities like the Eastern Shore of Maryland

Data Collection

Psychiatric Telehealth

- Average wait time
- 30-day ED revisit rate
- Patient satisfaction
- Provider satisfaction

Palliative Care Telehealth

- Patient acceptance rate
- ED use
- 30-day readmission rate
- Hospital admission rate
- Advance care planning
- Patient/family satisfaction
- Provider satisfaction

Outcomes

Psychiatric Telehealth

- Reduction in average wait times
- Unchanged ED revisit rate
- High patient satisfaction and provider satisfaction

Palliative Care Telehealth

- High acceptance rate
- Three-fold increase in patient volume
- Fewer hospital admissions
- Fewer 30-day readmissions
- Improved advance care planning
- High patient and provider satisfaction

Challenges

Psychiatric Telehealth

- Buy-in from frontline staff
- Resources for project development
- Train large pool of nurses
- Sound quality

Palliative Care Telehealth

- Buy-in from referral sources
- Physical examination
- Lighting/Audio
- Wireless connectivity

Solutions

Psychiatric Telehealth

- Visit to an established telepsychiatry program
- Strong support from leadership
- Laminated instruction cards
- Video training
- Upgraded speakers, microphones, headsets

Palliative Care Telehealth

- Systematic education with multiple modalities
- Examination camera
- Headphones
- Assistance from Palliative Care nurse
- Dedicated space at nursing home

Project Observations

Psychiatric Telehealth

- Improved access
- Solid patient acceptance
- Positive provider acceptance
- Patient safety in the ED

Palliative Care Telehealth

- Improved access
- High patient/family acceptance
- Improved quality metrics

Sustainability

Telehealth services continue after grant period

Evolving reimbursement for telehealth clinical services

Telepsychiatry services have been further expanded

Palliative Care Program plans to scale telehealth services

JOHNS HOPKINS
MEDICINE

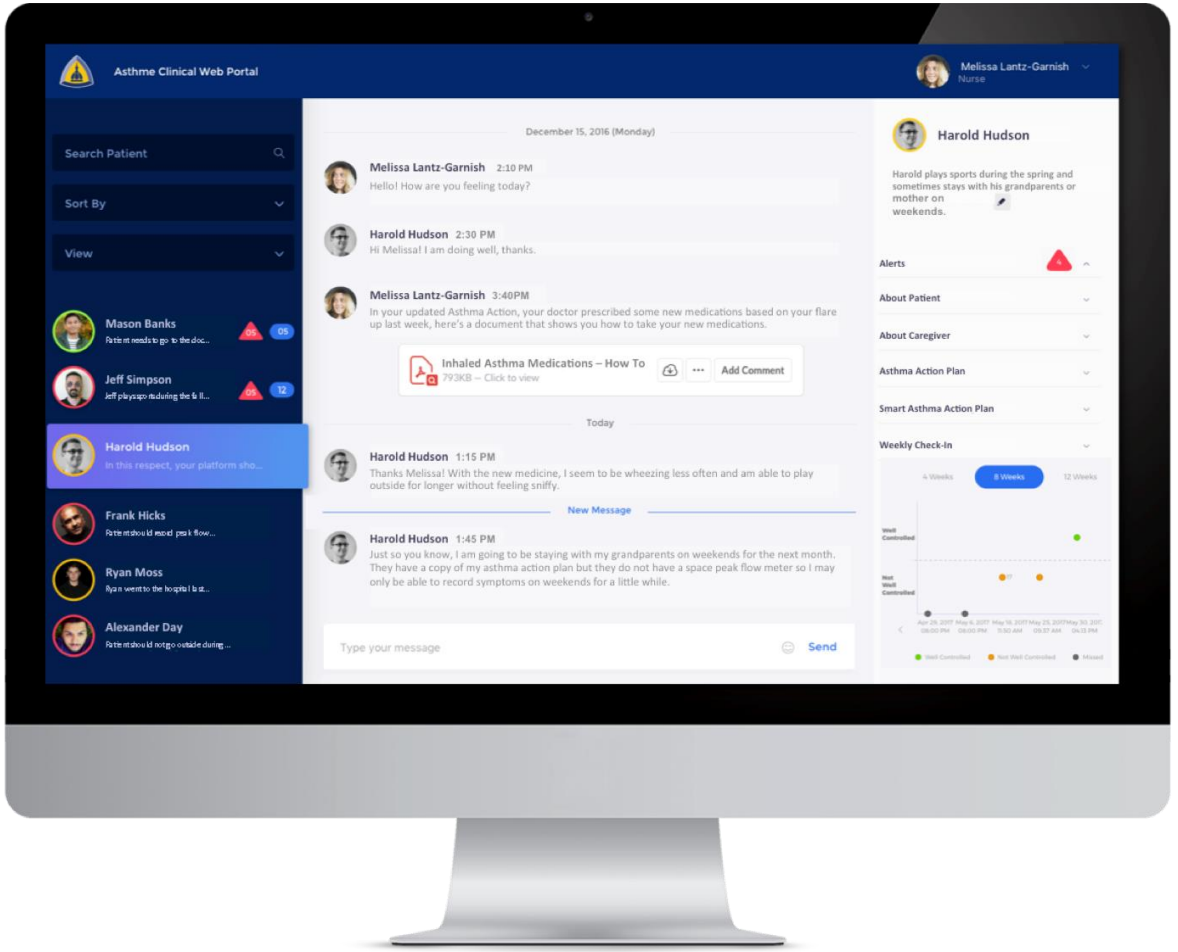
JOHNS HOPKINS
HOME CARE GROUP

Remote Patient Monitoring for Children with Asthma

Developed by Pediatrics at Home in collaboration Quantified Care

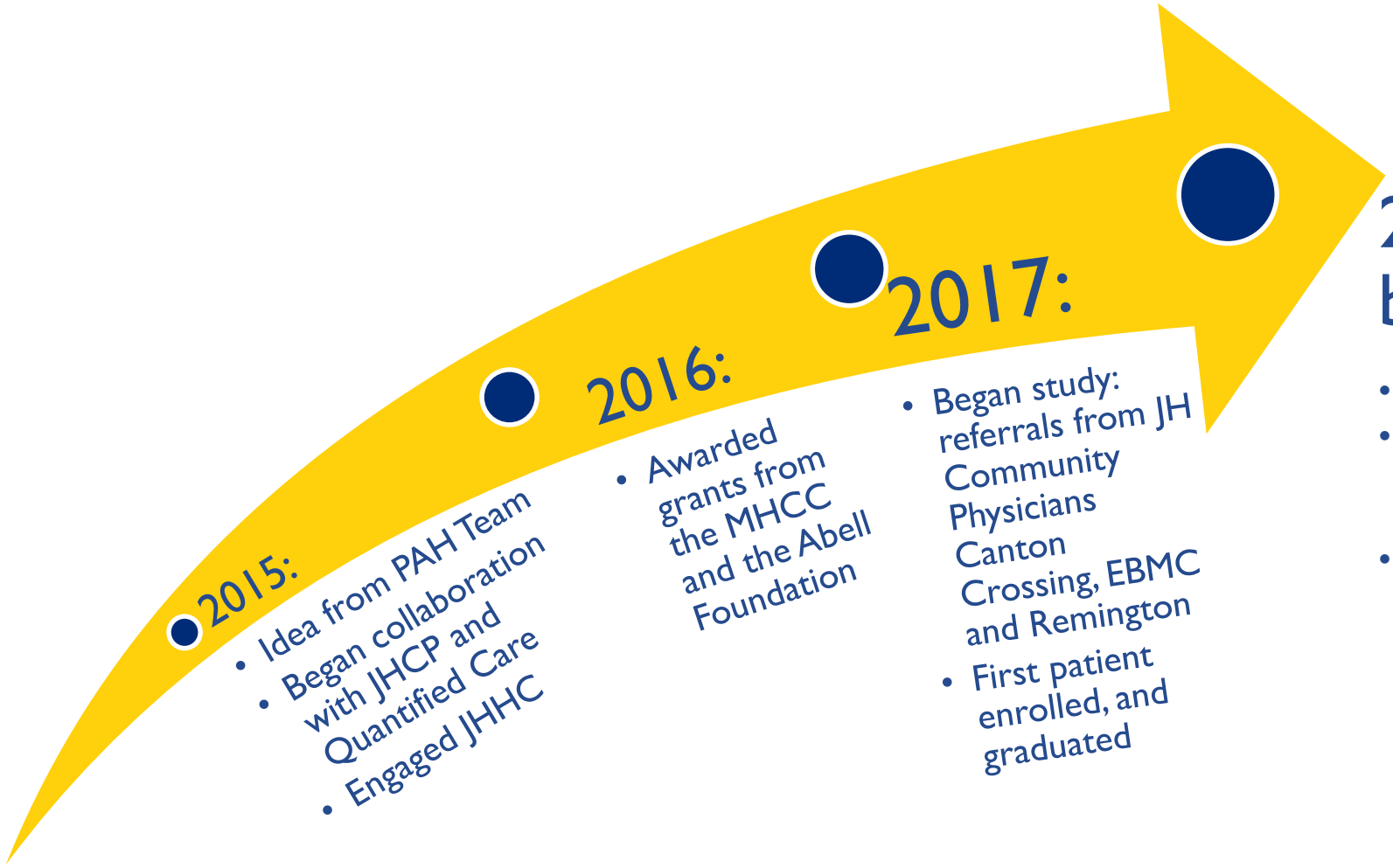
Agenda

- About the Project
- Data Collection
- Outcomes
- Challenges
- Solutions
- Project Observations
- Sustainability



About the Project:
Remote Patient Monitoring for Children with Asthma

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HOME CARE GROUP



2018 and beyond:

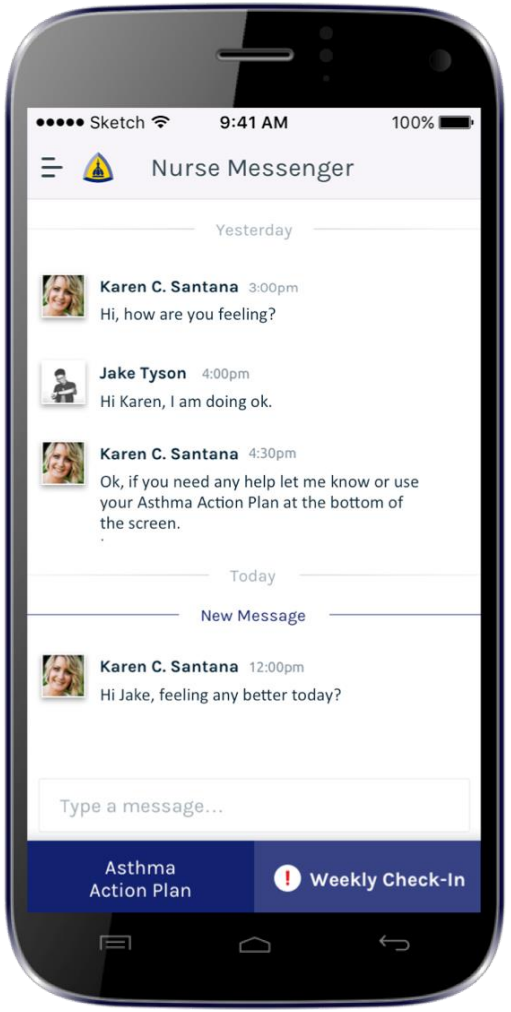
- End of study
- Goal: Secure funding to sustain, scale and enhance
- Plan to publish

A Comprehensive Program

Mobilization of asthma care

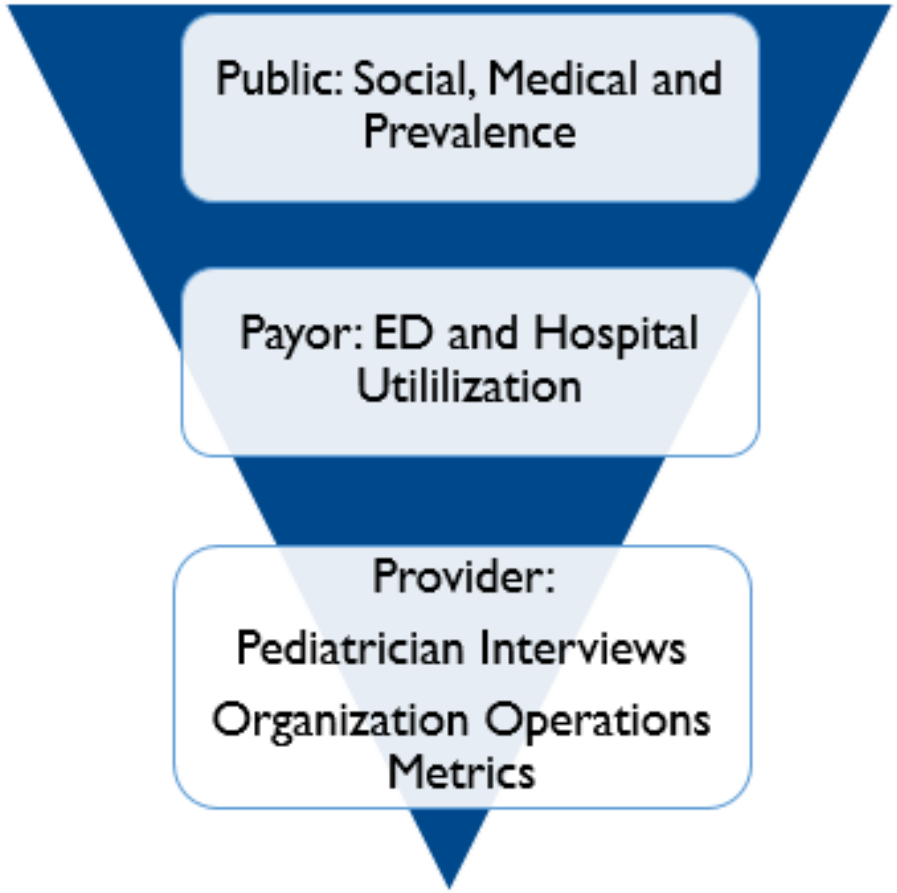
Home Care Clinician:

- Conducts an in-home environmental assessment and advises for asthma trigger remediation
- Pre-screens to identify the primary user (patient or caregiver)
- Teaches the use of the mobile application
- Securely communicates, oversees pushed education and reviews reported symptomology data
- Oversees the patient's 'smart' asthma action plan



Data Collection

Validating the Need



Program Analysis

- Outcomes:
  - Patient/Provider Engagement
  - Clinical
  - Patient/Provider Satisfaction
- Gathered via:
  - EHR chart review
  - Technology usage
  - Surveys (patient/caregiver and provider)

Outcomes

Criteria:

- Ages 5-21
- Referred from JHCP Canton Crossing, East Baltimore Medical Center, and Remington
- Graduate at 90 days

Measure	Amount	Description
Participants	77	99% Medicaid
Graduates	62	90-Day Program
Engagement	87%	Users engaging at least 4 times per 30 days
Reduction in High-Cost Utilization (Comparison for ED Visit, Hospitalization or UC Visit)	55%	Year-over-Year, Same 90-day
	79%	Same Year, Pre/Post 90-day
	55%	Same Year, Pre/Post 180-day
Patient/Caregiver Satisfaction	97%	Tests for Satisfaction and Technology Acceptance
Provider Satisfaction	100%	Eight out of Thirteen Referring Pediatricians Responded

Challenges

- Recruiting
  - Initial site overestimated number of patients it would refer
  - Pediatricians' competing priorities allowed for potential for patients to not be identified

- EPIC Integration
  - Process to integrate the technology with EPIC to streamline the communication between the PAH clinician and referring physicians

Solutions

- Recruiting
  - Expanded to two additional JH Community Physician sites
  - Ongoing program updates to each site and created a sense of competition amongst them
  - Identified that a scribe was instrumental in identifying patients

- EPIC Integration
  - With outcomes data to validate the program, resources are now being sourced to integrated with the EHR

Project Observations

- Diversity among the project team skills to address the clinical, administrative, and technological components of the project can increase the project's success
- Frequent communication with stakeholders engenders better results
  - Referring Pediatricians
  - Funding Sources
- Applying for multiple grants increases your chances of getting funded
- Analyzing results on a rolling basis allows for faster innovation
- Thanks to the MHCC, we were able to make a true impact!

Sustainability

Future Endeavors:

- Secure funding to sustain the program, while also expanding patient population and geography served
- Present at Vizient Connections Summit in October
- Publish a white paper and/or academic journal article
- Partner with Payors for Alternative Payment Model
  - CareFirst, AmeriHealth in DC, JHHC have all expressed interest
  - Work with Maryland Medicaid to expand coverage to asthma under its Remote Patient Monitoring reimbursement
- Partner with Howard County's Local Health Improvement Coalition

On the Horizon

- Both grantees are preparing implementation guidance documents to serve as a blueprint for similar telehealth projects
  - UM SRH is preparing a Teleheatlh Tool Kit
  - PAH is developing a Pediatric Asthma Roadmap
- Release date is anticipated in October

Thank You!

The MARYLAND
HEALTH CARE COMMISSION

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AGENDA

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3. ACTION: Certificate of Need – Children's Hospital (a subsidiary of Children's National Medical Center, Inc.) - Docket No. 18-16-2413
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7. PRESENTATION: 2017 Findings: Health Care Data Breaches in Maryland
8. PRESENTATION: Telehealth Grant Findings: Johns Hopkins Pediatrics at Home Health East Baltimore Asthma Assessments, and University of Maryland Shore Regional Health Palliative Care/Emergency Department Psychiatric Services in rural communities of the Ea
9. **PRESENTATION: Maryland Health Workforce Study**
10. OVERVIEW OF UPCOMING INITIATIVES
11. ADJOURNMENT

MARYLAND HEALTH CARE COMMISSION

PRESENTATION:

Maryland Health Workforce Study

(Agenda Item #9)

IHS Markit™

Maryland Primary Care and Selected Specialty Health Workforce Study

Overview of Key Study Findings

September 20, 2018

Study Goals

- Report health care workforce characteristics, current distribution at State and county levels, and projected supply and demand through 2030
  - > Include primary care and behavioral health providers
  - > Include three additional physician specialties (Cardiology, General Surgery, Thoracic Surgery); obstetrics/gynecology also modeled
- Model health workforce supply and demand through 2030 assuming different levels of Maryland Primary Care Program (MDPCP) participation
  - > Assuming participation by 2,500 primary care providers
  - > Assuming participation by 4,000 primary care providers
  - > Compare projections to status quo projections

Provider Categories Modeled

Categories	Occupations
Primary Care	Family and General Practitioners
	General Internists
	Geriatricians
	Pediatricians
	Family Nurse Practitioners
	Adult Nurse Practitioners
	Geriatric Nurse Practitioners
	Pediatric Nurse Practitioners
	Physician Assistants
Specialty Care	Obstetricians and Gynecologists
	OBGYN Nurse Practitioners
	General Surgeons
	Cardiologists
	Thoracic Surgeons
Behavioral Health	Psychiatrists
	Psychiatric Nurse Practitioners
	Psychologists
	Mental Health Counselors
	Addiction Counselors
	Marriage and Family Therapists
	Social Workers

Data and Methods Overview

- Use Maryland data where possible
  - > Licensure files on size, location and characteristics current supply; labor force participation patterns; and trends in new entrants
  - > Demographics, prevalence of disease, socioeconomic factors and insurance coverage, other risk factors (smoking, obesity)
- Use same workforce projection models used for previous Maryland health workforce projections, used by federal government, and used by other states

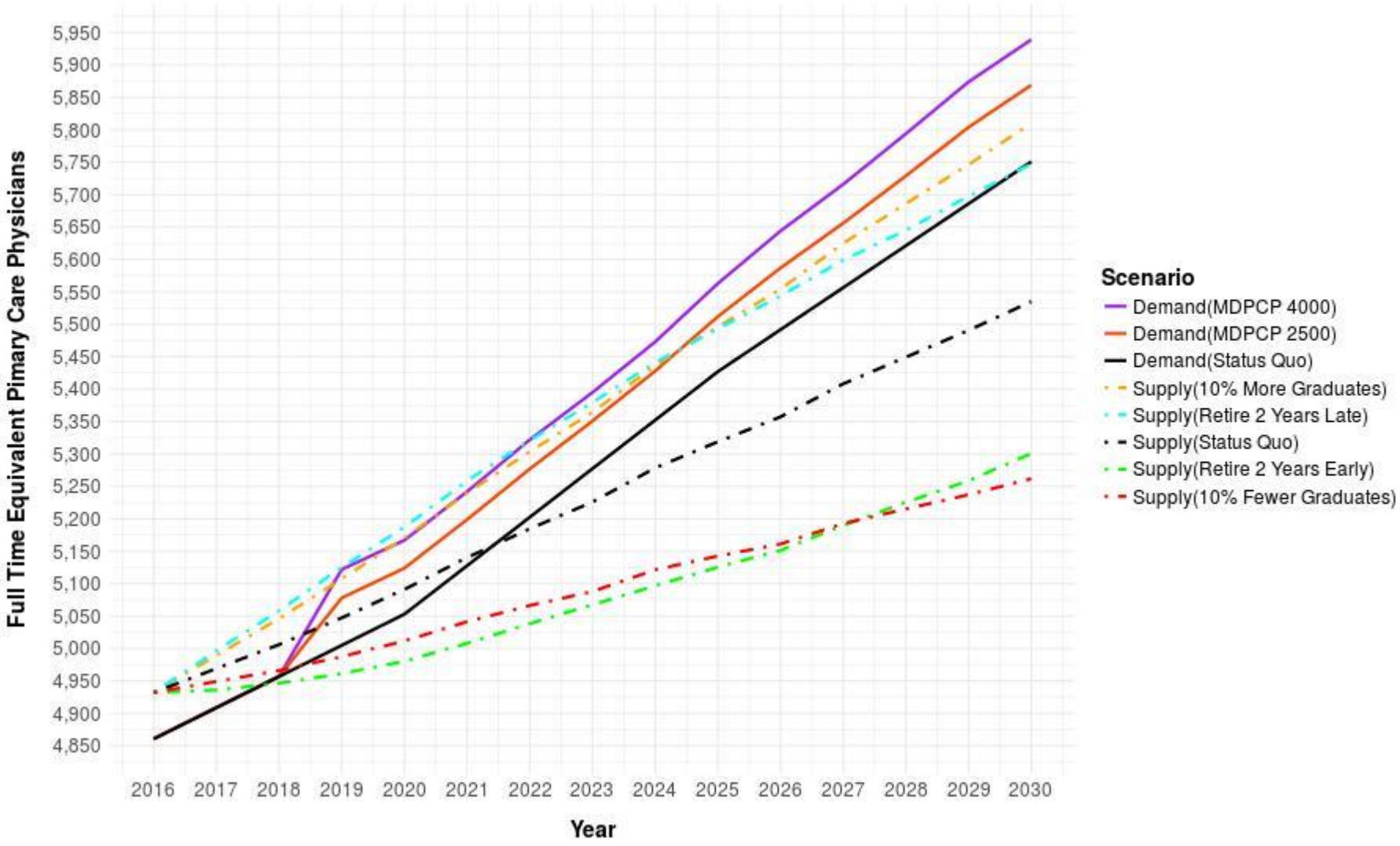
Workforce Supply Scenarios

- **Status quo**: continuation of current trends in numbers and characteristics of providers entering the workforce, hours worked, and retirement patterns
- **New entrants** to the workforce: assumptions around the number of new clinicians annually entering Maryland's workforce (±10% change in annual new entrants)
- **Early and delayed retirement**: assume providers retire two years earlier or later, on average, relative to current patterns

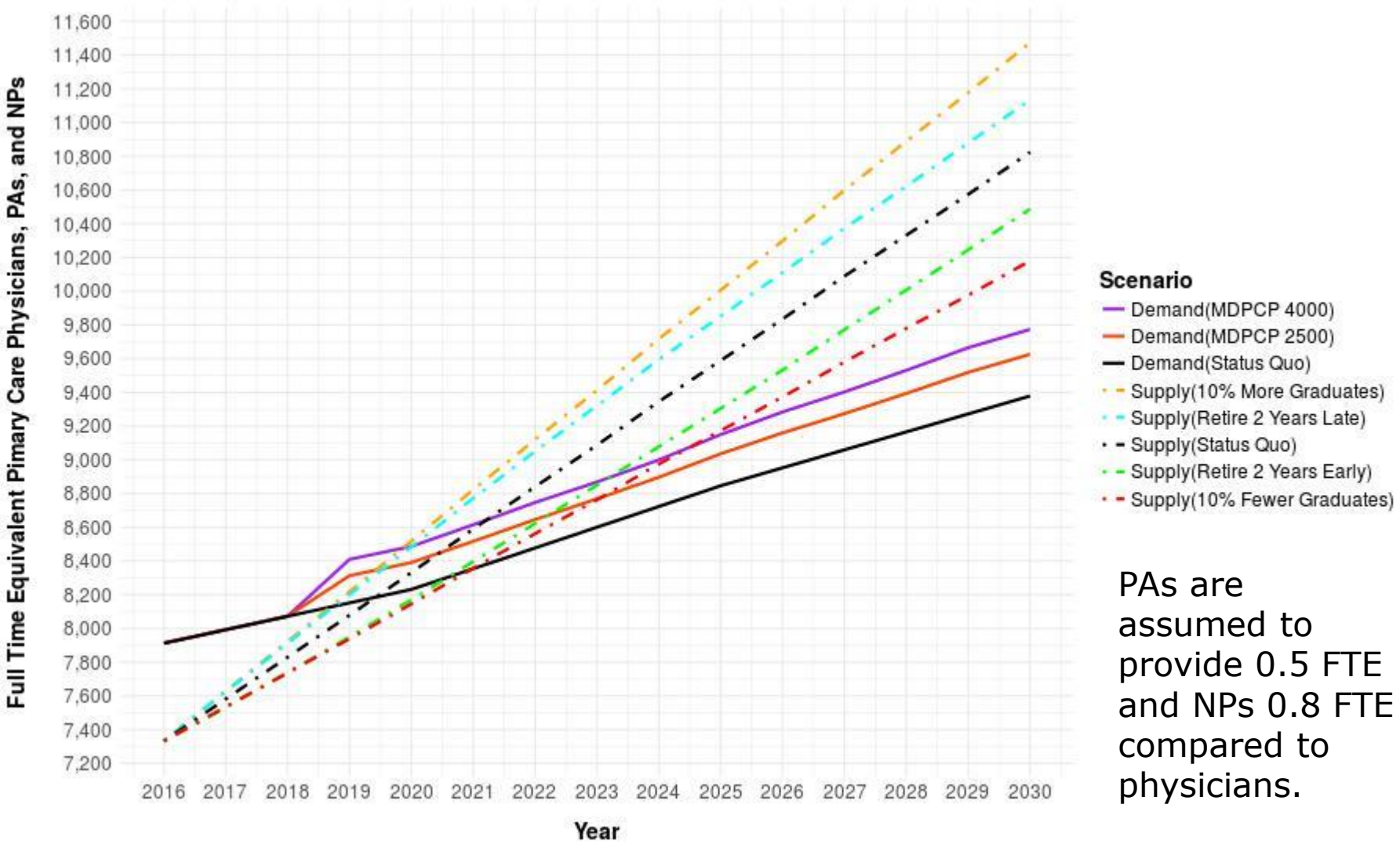
Workforce Demand Scenarios

- **Status quo**: Continuation of current care use an delivery patterns, using national averages adjusted for the characteristics and socioeconomic situation in Maryland relative to the national average
- **Needs scenario** (for behavioral health occupations): This scenario reflects national estimates that about 20% of behavioral health needs are currently unmet (same scenario run for HRSA and American Psychological Association)
  - > Reflects efforts to increase access to behavioral health services through better integration of behavioral health into primary care, telemedicine, and other efforts
- **MD Primary Care Program implementation**: This scenario attempts to model improvements in delivery of primary care
  - > Question 1: How will program change patient outcomes over time?
  - > Question 2: How will program change how care is delivered (e.g., panel size for primary care providers, referral patterns)?

Primary Care Physician Projections

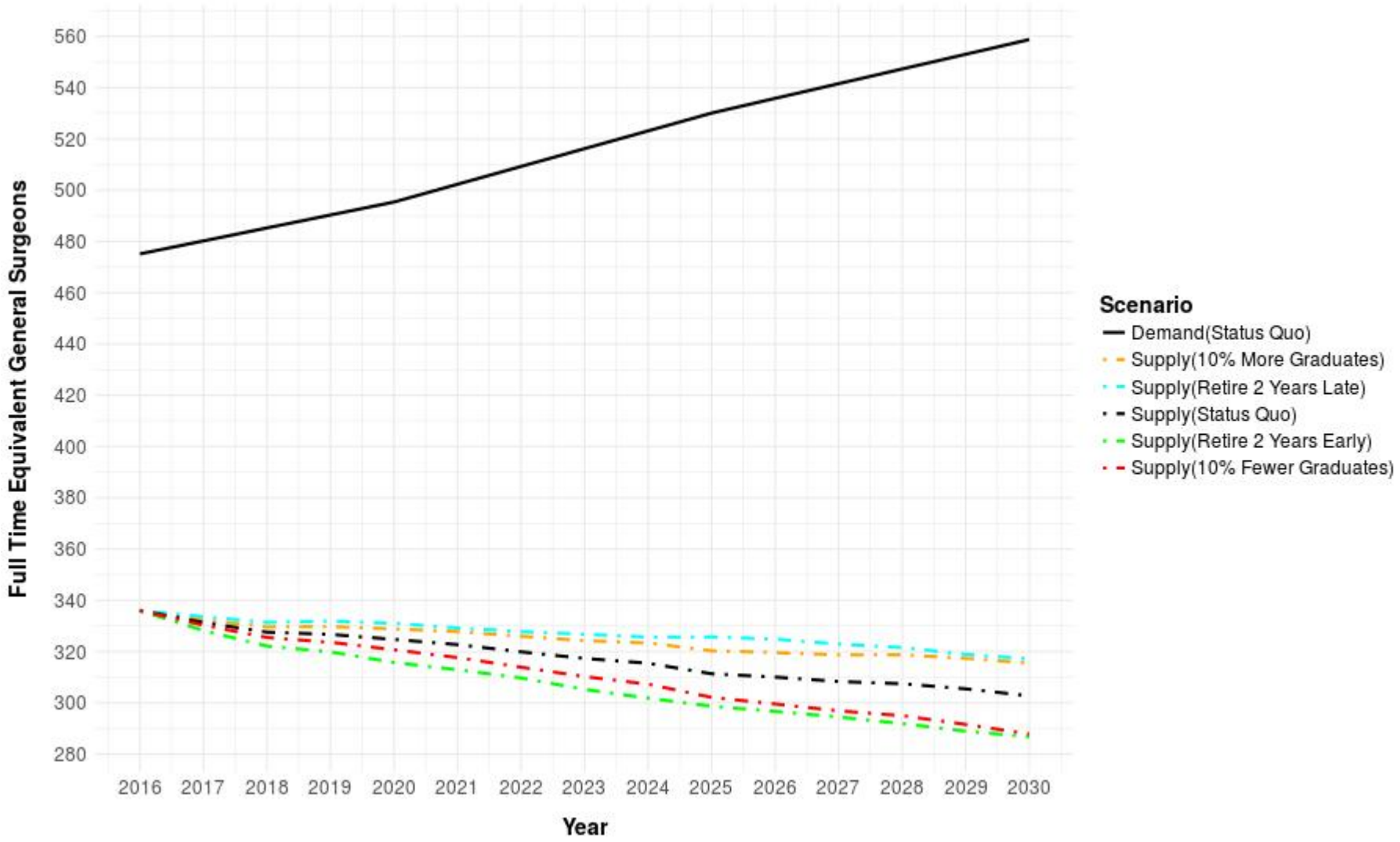


Primary Care Physician, NP, and PA Projections

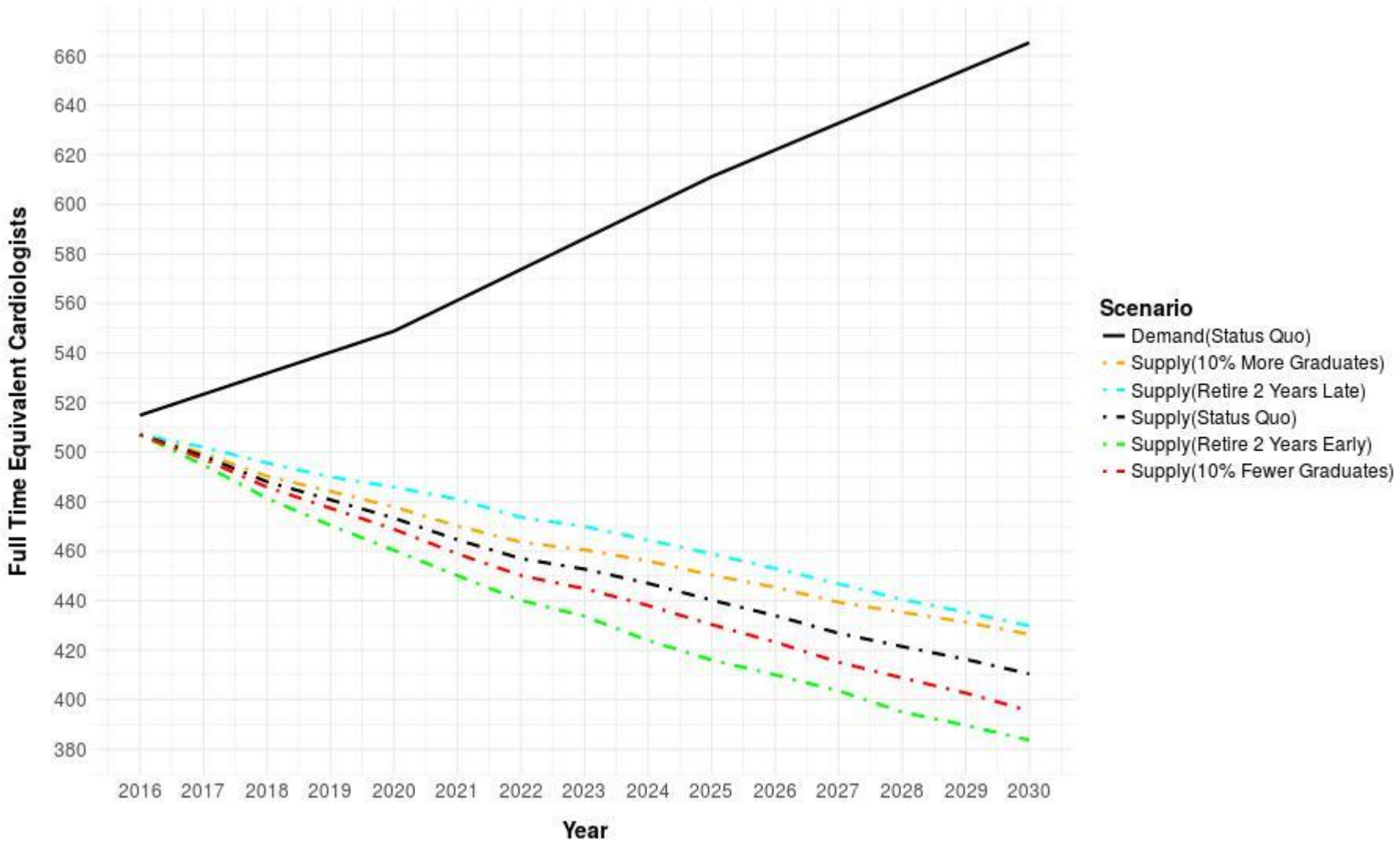


PAs are assumed to provide 0.5 FTE and NPs 0.8 FTE compared to physicians.

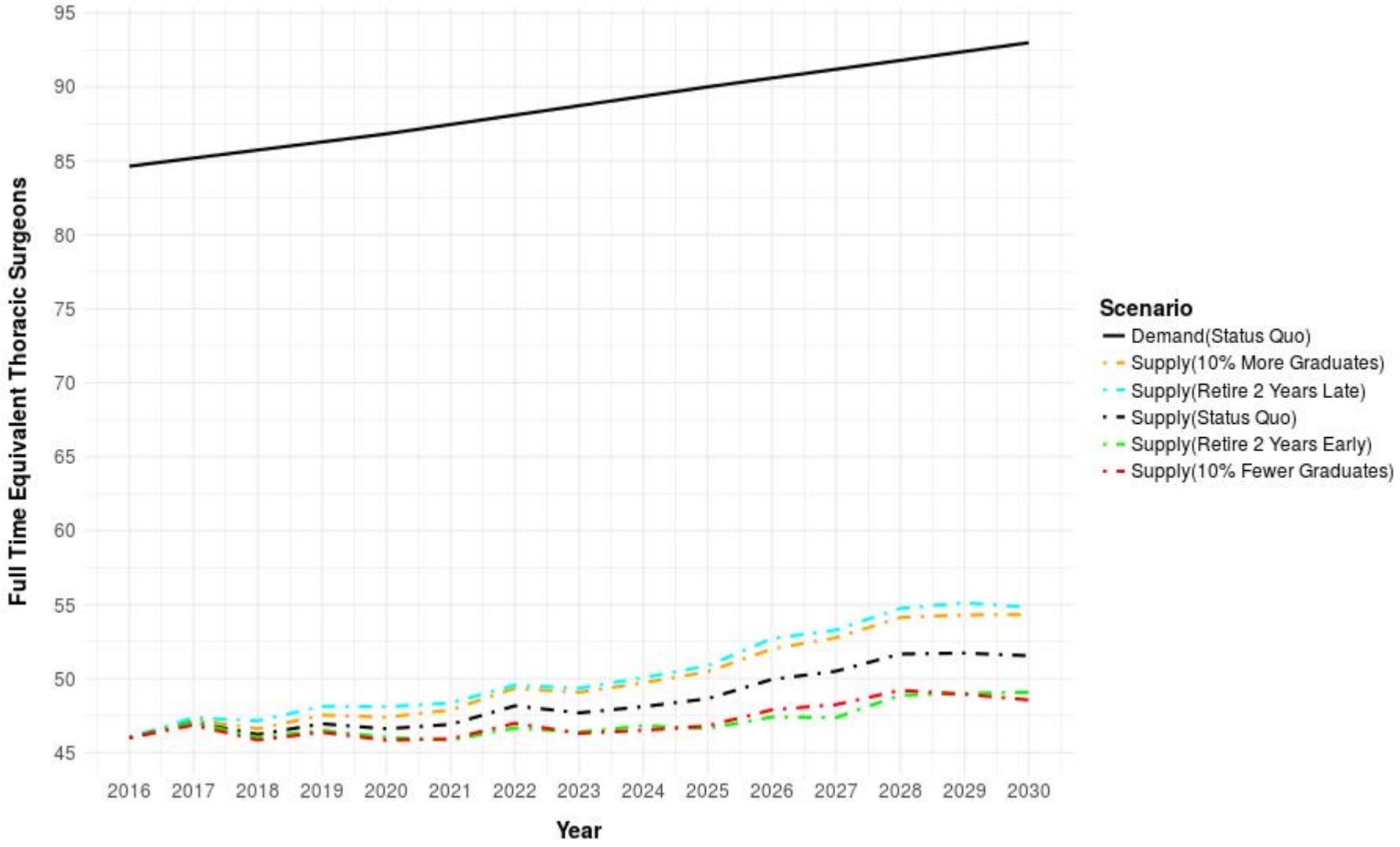
General Surgeon Projections



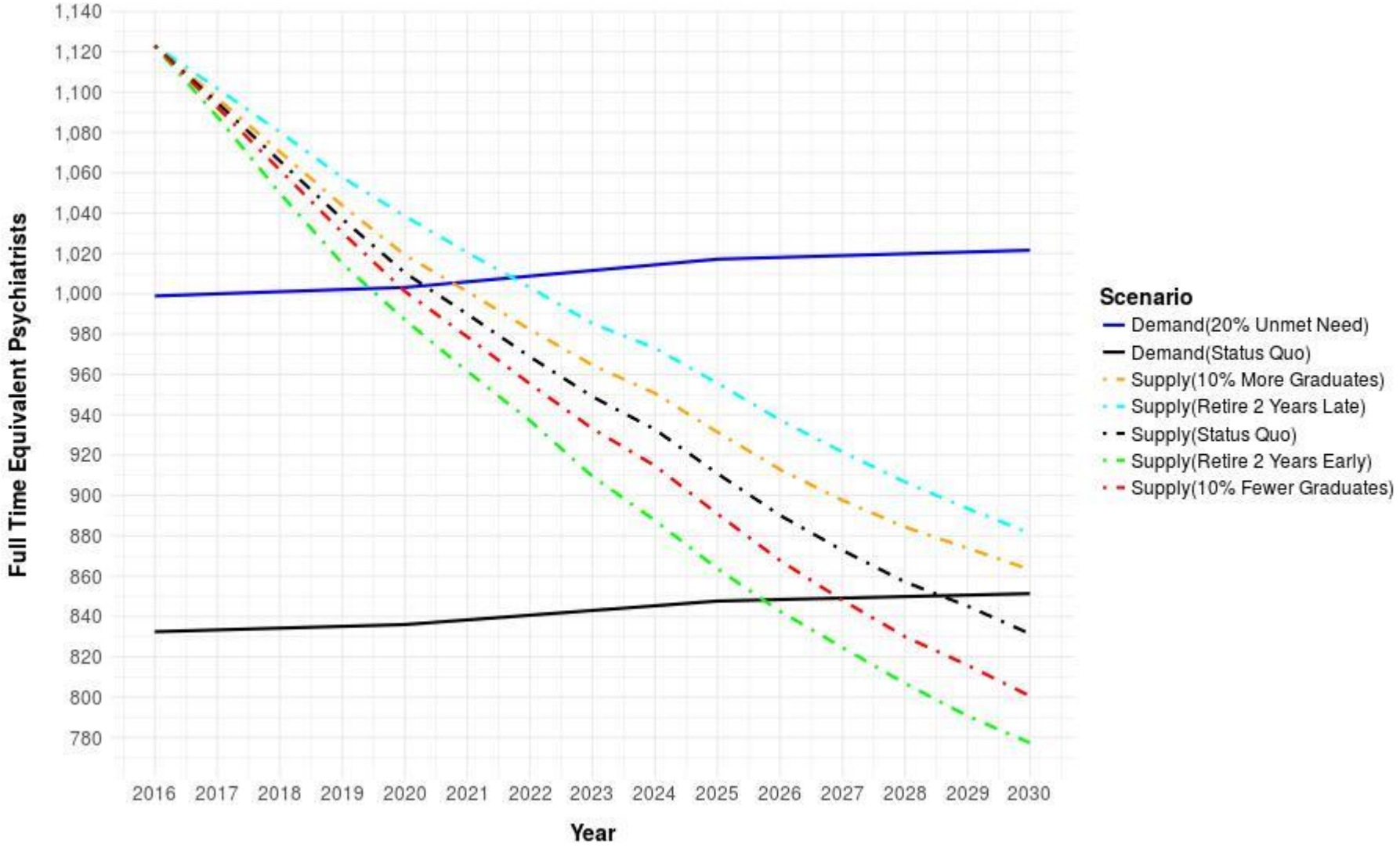
Cardiologist Projections



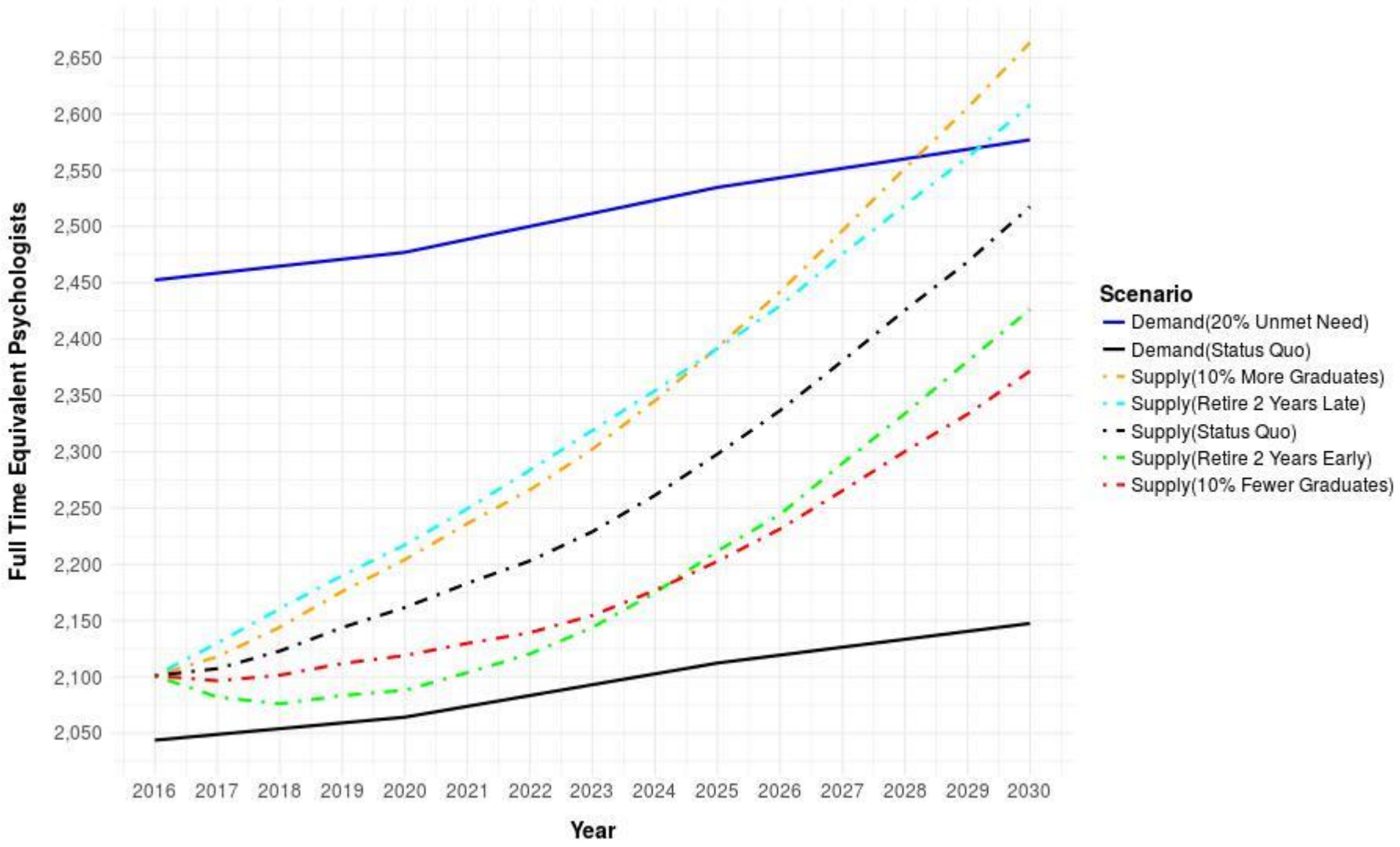
Thoracic Surgeon Projections



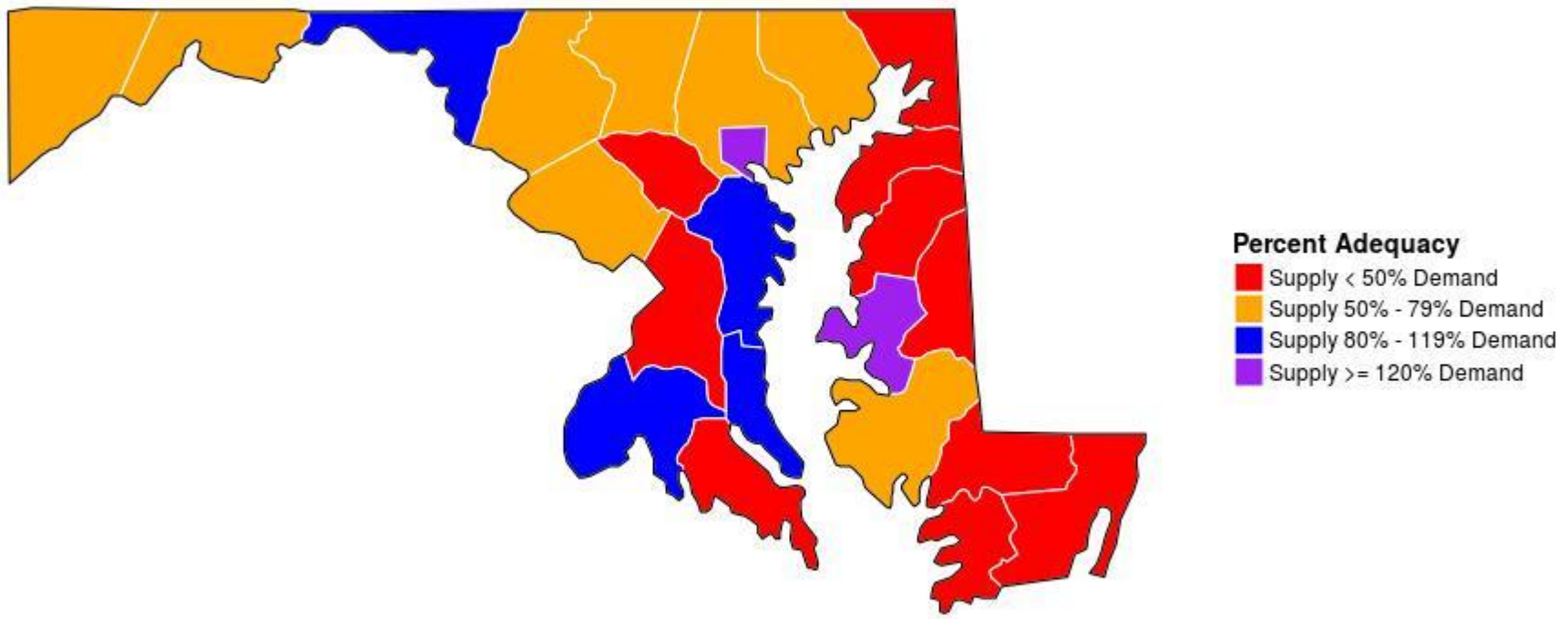
Psychiatrist Projections



Psychologist Projections



Cardiologists, 2030: 100% = Supply Adequate to Provide National Average Level of Care



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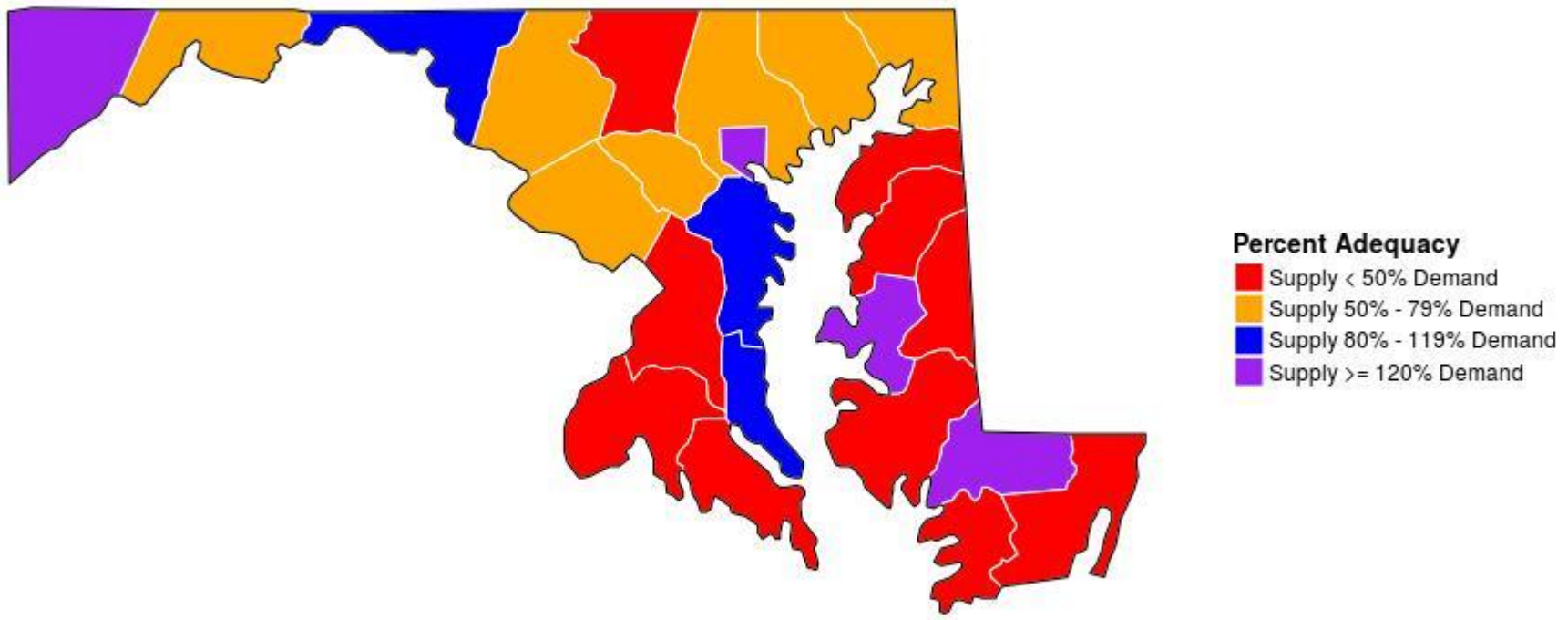

Key Take-aways

- Maryland has better workforce data than most states, but still some data limitations for making projections
  - How will care delivery patterns change over time?
  - How much cross-state care delivery takes place?
- Like national trends, Maryland's…
  - Primary care physician supply of is growing slower than demand, but rapid growth in supply of advanced practice providers should be enough to offset physician shortfalls
  - Psychiatrist supply is falling; national data suggests rapid growth in psych NPs and PAs will be insufficient to close shortfall and address unmet needs; national supply of social workers, psychologists and others is growing but these occupations have limited medication proscribing privileges
  - Supply of select surgical specialties is not growing while demand is growing; national shortfalls could exacerbate challenges to recruit/retain surgeons
  - Substantial geographic maldistribution in provider supply

MARYLAND HEALTH CARE COMMISSION

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MARYLAND HEALTH CARE COMMISSION

Overview of Upcoming Initiatives

(Agenda Item #10)


ENJOY THE REST OF
YOUR DAY